The CHILD
Monthly Bulletin

Courtesy of Federal Works Agency

THESE CHILDREN ENJOY NURSERY SCHOOL WHILE THEIR PARENTS WORK

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

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THE CHILD

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• CHILD WELFARE •

• SOCIAL SERVICES •

• CHILD GUIDANCE •

Program for Care of Children of Working Mothers

THE CARE of children whose mothers are being drawn into employment as a result of the defense program was the subject of a 2-day conference held at the Children's Bureau, Washington, on July 31 and August 1, 1941. The conference was called by Katharine F. Lenroot, Chief of the Children's Bureau, who is Child Welfare Consultant to the Coordinator of Health, Welfare, and Related Defense Activities. In this capacity she is responsible, through the Children's Bureau, for assisting the Coordinator in planning for the protection of children during the national-defense emergency.

The conference heard reports from Charles P. Taft, Assistant Coordinator of Health, Welfare, and Related Defense Activities; Col. Frank McSherry, Director of Defense Training; Mary Anderson, Director of the Women's Bureau; and Martha M. Eliot, M. D., Associate Chief of the Children's Bureau, who visited England last winter as a member of a Civil Defense Mission and whose particular concern was with measures for the protection of children. Members of the conference reported and discussed the situation as it is developing in the various parts of the country, the forms of day care for children that should be provided, and the coordination and development of community day-care programs and services.

The committee on statement of principles, headed by Paul L. Benjamin of the Council of Social Agencies, Buffalo, N. Y., drew up a 10-point program which was adopted by the conference in the following form:

We recognize the extreme importance of national defense, and the necessity of maintaining the democratic way of life which makes successful defense imperative. Toward this end we believe that every effort should be made to safeguard home life, to strengthen family relationships, and to give parents a direct opportunity to participate in community planning.

1. In this period when the work of women is needed as an essential part of the defense program it is more than ever a public responsibility to provide appropriate care of children while mothers are at work.

2. The conference group on the Provision Needed for Daytime Care of Children of Working Mothers urges that every effort be made to maintain standards that have been achieved relating to the employment of working women and to extend these standards where they fail to provide safeguards generally recognized as essential; and recommends that a joint meeting of the Labor Advisory Committee of the Women's Bureau and a committee representing this group be held in the near future to discuss how these standards may be maintained and extended.

3. The welfare of mothers and children should be given due consideration at every point in the development of employment policies relating to national defense. Mothers who remain at home to provide care for children are performing an essential patriotic service in the defense program.

4. Advance information concerning plans for increased employment of women should be made available to community agencies in order that parents, public and private agencies, schools, and industry may plan together for the care and protection of children.

5. Working mothers who cannot make arrangements for adequate care of their children by relatives or friends must rely upon nurseries, child centers, and other forms of community day care. Community plans for the care and protection of children of working mothers should include as many of the forms of day care as are required to meet needs of children of all ages for whom such provision should be made. These activities should be integrated with the whole community program for public and private family assistance, social services to children, health protection, education, and recreation.

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Included in such plans, individual counseling service provided as part of a unified community program should be available for mothers planning to enter employment or already employed. The object of this service is to assist parents in making plans which will safeguard family life and make adequate provision for the health and welfare of parents and children.

6. Nursery schools, nursery centers, and cooperative nursery groups should be developed as community services, under the auspices of public or parochial schools, welfare departments, or other community agencies. They should not be located in industrial plants or limited to children of mothers employed in particular establishments. Infants should be given individual care, preferably in their own homes and by their own mothers.

7. The standards of personnel, equipment, procedure, and care generally recognized as acceptable by health, educational, and social organizations should apply equally to all types of nursery schools and day-care centers.

8. Other forms of care such as day care in foster homes, housekeeper service, day camps and vacation camps, leisure-time and after-school programs, and other types of service which may be developed, should be planned and conducted as part of a comprehensive community program. All such programs should be conducted in accordance with recognized standards which will assure qualified personnel and adequate service.

9. Federal and State agencies and national organizations have a continuing responsibility for exerting leadership in upholding standards of child care. These agencies have the further responsibility of stimulating action by local communities and assisting them in their efforts to meet the increased demands for care and protection of children which have grown out of or have been augmented by the expansion of defense activities.

10. The development of the services needed to promote this program will require greatly increased personnel. We therefore recommend that careful plans be made for the selection, training, and supervision of competent workers in accordance with established standards.

After considering the problem of daytime care of children of working mothers in relation to other emergency problems of child protection—such as exploitation of child labor, mental hygiene, the possible evacuation of children, and problems that might arise as an aftermath of the emergency, the committee on plan of work, headed by Elizabeth W. Clark of the National Association of Day Nurseries, recommended the following plan for continuing committees, which was adopted by the Conference: An overall committee concerned with all phases of child care in connection with defense. A committee on care of children of working mothers with the following subcommittees: subcommittee on Federal-State responsibility; subcommittee on community planning for day care; subcommittee on standards and services for day care; and subcommittee on recruiting and training of personnel.

Citizen Responsibility

A Guiding Principle in Pennsylvania's Child-Welfare Services

By Elizabeth Taylor Shipley

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The two regional conferences of the child-welfare services in Pennsylvania, held in May 1941 in the eastern and western ends of the State, were significant events. These two meetings were attended by approximately 158 persons from 19 counties participating in child-welfare services, among whom were 20 county commissioners from 9 counties, members of the State-wide advisory committee to the Rural Child-Welfare Unit of the State Department of Welfare (which administers child-welfare services in Pennsylvania), members of the advisory committees in the various counties, State and local staff members of the child-welfare services, and other interested persons.

These conferences brought together from widely separated rural areas county officials, State and Federal representatives, and private citizens, to spend a day of earnest and eager consultation on how each one in his own setting, and all of us together, might serve better the dependent and neglected children in our midst.

What was it that made this conference possible and what seems to have come out of it?

In Pennsylvania the tradition of the responsibility of the private citizen for the development and vitalizing of public-welfare services has been a long and honorable one. Although we have never fully lived up to this tradition, there has always been some leavening influence to keep us reminded of it. A brief review of the history of child-welfare work in Pennsylvania shows devoted individuals promoting the movement to remove children from almshouses and jails; starting institutions which they called "children's homes"; and later, recognizing that institutional homes could not take the place of family homes, starting child-placing organizations in order to build up a system of private foster care to supplement the care given in the group programs. Growing recognition of the safeguards necessary in institutional or foster-home settings, of the value of the child's own home for him, and the emergence of our present-day concepts of what constitutes understanding and responsible care of dependent and neglected children, have all been due to the vision, insight, imagination, and courageous action of individuals who became leaders in the service of children in need of care. The Rural Child-Welfare Unit has included participation of private citizens and their sharing of responsibility with public officials as one of the bases on which the child-welfare services are built.

Under the provisions of the County Institution District Law of 1937, county commissioners became responsible for the care of dependent children—an obligation formerly lodged with local directors of the poor—and the State Department of Welfare was made responsible for the establishment of rules, regulations, and standards for the guidance of the county commissioners in the fulfillment of this task. Many of these county commissioners had had no former experience in administering direct services to persons in need, and in most of the rural counties there were no private child-caring agencies with recognized standards to which the county commissioners could turn for help or advice. In the development of the child-welfare-services program in the State, therefore, the Rural Child-Welfare Unit planned service to these dependent and neglected children, many of whom were already separated from their own homes, through helping the county commissioners to strengthen their own services. Federal funds made available for child-welfare services have been used to provide the county commissioners in 19

counties with county child-welfare secretaries equipped by personality, training, and experience to plan and care for the dependent and neglected children for whom the county commissioners must be responsible. County commissioners provide the costs of direct care (board payments, medical care, and clothing) for the children, and provide office space and equipment, transportation costs, and in some cases, stenographic service; sometimes, where case loads are high, they also pay the salaries of additional children's workers.

But such a program is very new in most of these counties, and county commissioners are often fearful of criticism of their "lavish" expenditures for the wards of the county. They need the understanding and backing of local citizens. Citizens of the county also need to understand the differences between a responsibility *responsibly* carried and the type of care formerly given in a hit-or-miss fashion, which at best had little but good will and intent to commend it and at worst meant exploitation or neglect of the small charges of the county. Therefore the practice of asking "lay" citizens to serve in an advisory capacity has been followed in the counties as well as in the State administration of the child-welfare services. Before the Rural Child-Welfare Unit enters into an agreement to supply the services of a child-welfare secretary in any county, a definite plan, which includes the setting-up and the use of an advisory committee of citizens, is signed by the county commissioners, the Secretary of Welfare, and the supervisor of the Unit.

As the program has developed, this citizen participation and sharing of responsibility has become a very real force in procuring for children the consideration which is their right. A State-wide advisory committee appointed by the Secretary of Welfare, and made up of persons who in their professional fields or in their private capacity have demonstrated a particular interest in children, discusses with the supervisor policies and plans for the development of child-welfare services throughout the State and works with the supervisor and the Secretary of Welfare on such problems as the establishment of a merit system, the annual plan and budget, and matters affecting the various counties. It was this State-wide advisory committee that took responsibility for planning, with the Unit staff, for the regional conferences of the county advisory committees, and both of these conferences were attended by members of the State-wide committee, who took active and interested part in them.

At these regional conferences we could see for ourselves the relationship of mutual confidence and respect that is developing between county commissioners and committee members, as each committee reported on its own services. The chairman of one advisory committee reported:

> Our relationship to the commissioners has been a happy one. The commissioners have given our group wide latitude in the selection of committee members. The commissioners have taken a vital interest in the program.
>
> I feel much more certain now than I did 2 years ago of the necessity of having an advisory committee, and I begin to see more clearly the real help and the positive function of such a committee. So far as my own contacts in my own community have been concerned, the child-welfare situation had been positively barbarous and uncivilized. The commissioners have rendered a greater service than they realize by making this possible. The agency (the county child-welfare services) has established something new which represents a great step forward in our county.
>
> As far as advisory committees are concerned, I believe it is our responsibility first of all to take pains to understand; second, to really care for the welfare of children; third, to defend such care given on high standards; fourth, to promote interest in such care; and, finally, to seek in every possible way to maintain the agency as one of the civilized forces in our community life.

The outreaching of the advisory committee in another county from the particular needs of children under the child-welfare services to a general need of children in the county was evidenced in another report:

> A dental committee was appointed (as a subcommittee of the county advisory committee) to work with other groups toward the establishment of a dental clinic at the hospital, this clinic to be used by all of the children in the county needing its services. The chairman of the committee secured the information from the State Department of Health that it would pay $40 per month for the services of an interne or dentist if the project were supported by a tax-receiving body such as the county commissioners. The Dental Society would be able to secure the equipment at a low rate. The chairman thought that there would be money avail-

able from different interested groups, and now it is a question of developing further interest and putting into shape something for which there is a great need and readiness on the part of the community to meet the need.

One committee reported that, "When Bryn Mawr College asked the county secretary to supervise one of their Austrian refugee students for a brief period, the committee, with the approval of the county commissioners, interviewed her and took responsibility for her coming here."

Still other reports gave evidence of the strength given by the committees to the county commissioners, when, against local political or financial pressures, they were honestly and sincerely "trying to be their best selves" in relation to the children for whom they have been given responsibility—whether the question was one of personnel, or of board for children, or some other problem. At other times the committees have demanded that their elected officials should face squarely responsibilities which they seemed to be evading and have thus won the respect of the commissioners. This relationship has been reciprocal, and citizens who had little grasp of the pressures and responsibilities actually carried by the county commissioners have gained an understanding of the tasks which they themselves have placed upon their officials.

Reverberations since these regional conferences have proved their worth to those who took part. Advisory-committee members, formerly diffident about taking active part in county-committee meetings, have "spoken up" on the purposes or the extent of the child-welfare services throughout the country, or have cited reports given by other county communities suggesting constructive lines of service and hitherto unrecognized possibilities for action suited to the needs in their own counties.

All of us, I believe, renewed our courage and determination to go on together, in this Commonwealth of Pennsylvania, uniting our public and private efforts in the single purpose of serving each child and of promoting the welfare of all children in the State.

BOOK NOTES

PUBLIC RELIEF 1929–1939, by Josephine C. Brown. Henry Holt & Co., New York, 1940. $3.50.

"During the 10 years between 1929 and 1939 more progress was made in public welfare and relief than in the 300 years after this country was first settled." This statement is in the foreword of Josephine C. Brown's chronicle of the decade 1929–39. This decade is described as the most important in the history of public assistance in the United States, as marking the development of new trends, philosophies, and programs, based on a revolution in social thinking in the area of public responsibility for those in need. Because of Miss Brown's connection with the Federal Emergency Relief Administration and the programs of the Federal Government during this period, she is able to present well-documented material and to picture the philosophies and ideologies permeating the programs from the point of view of a participant as well as a historical observer.

The book is divided into four parts. Part 1 traces the history of public relief before the depression of 1929, starting with the local Poor Laws inherited from England and proceeding through the growth of public relief agencies and the gradual acceptance of relief as a well-defined responsibility of local and State governments.

Part 2, entitled "Unemployment Relief 1929–1933," presents vividly the drama of a nation whose resources, industrial and human, had been disorganized by the onslaught of the country's greatest depression. Here is shown an aroused public opinion demanding Federal aid to help local communities and States meet the mounting costs of relief to the unemployed. The battle for Federal relief is seen against the background of conflicting ideologies and a long history of local responsibility.

Part 3, on the Federal Emergency Relief Administration, gives the history of two Federal relief and work programs—FERA and WPA—and describes the planning for the later programs of social security. Here are set forth the problems of administration of these huge programs, the philosophies, attitudes, and methods permeating the FERA and other programs during this period. This section of the book brings out the contributions to a permanent program made by the FERA: Its emphasis on high standards of personnel, administration, and assistance; its gesture in making funds available in its last grant for the training of personnel; the setting of the stage for a more permanent program.

Part 4, entitled "The Beginning of a Permanent Program: 1935–1939," describes the passage of the Social

Security Act, reorganization of the Federal agencies under the general reorganization plan of the Federal Government, and the growth of State and local public-welfare agencies under the impetus of grants-in-aid programs under the Social Security Act.

The appendix contains various memoranda and press releases of interest, as well as statistical and financial charts and tables. The bibliography in the appendix lists about 500 references.

C. I. S.

FEDERAL AID AND PUBLIC ASSISTANCE IN ILLINOIS, by Arthur P. Miles. University of Chicago Press, Chicago, 1941. 259 pp. $1.50.

This is a study by Arthur P. Miles, assistant professor of social economics, School of Social Work, Tulane University, of public assistance in Illinois from the beginning of the Reconstruction Finance Corporation grants in the early period of the depression to the present day. The editor's note by Sophonisba P. Breckinridge points out that there will have to be many studies similar to this before all the lessons of this past decade of public assistance can be drawn. The introduction contains a brief but excellent statement of the system of "grants-in-aid."

Starting with the RFC, the study presents the experience of Illinois throughout the programs of Civil Works Administration, Federal Emergency Relief Administration, the pronounced effect of the withdrawal of Federal aid upon the dissolution of the FERA, and Federal grants-in-aid under the Social Security Act. In the final chapter of summary and conclusions the author recommends the establishment of a general-assistance program as part of the public-assistance provisions of the Social Security Act and makes various other recommendations including proposals relative to the administrative set-up of public assistance in Illinois. As regards the Division of Child Welfare, he recommends:

"The division should be retained and strengthened within a department of social welfare. It should not only continue its present work but should have supervisory responsibility for an aid-to-dependent-children program. The protection and care of children differs considerably from the administration of outdoor relief for the unemployed, the blind, and the aged. Such services, although administered through the same State and county agencies as the other assistance programs, require separate supervision and local administration through specialized rather than so-called 'undifferentiated' case work."

Studies similar to this in every State would supply the gaps in current literature of Federal-State relationships in the field of public assistance since 1930 and would provide basic information for future planning.

GUIDANCE IN DEMOCRATIC LIVING, by Arthur D. Hollingshead, Ph. D. D. Appleton-Century Co., New York and London, 1941. 260 pp. $1.80.

The origin of this book is traced to a quotation from Noah Webster, "If then the youth were to grow into citizens capable of furthering democracy, it must be by means of an education suited to a democracy." The book discusses a program for the utilization of the school situation as an opportunity for the students to acquire experience in managing their own behavior as individuals and as groups in ways designed to further the goals of democratic living. This program grew out of group thinking and experimentation on the part of the author and his teaching staff in 9 years of experience in an elementary-school setting.

• BIRTH •
• GROWTH •
• CHILD HEALTH •

A State Nutrition Program From the Nutritionist's Point of View[1]

By Catherine M. Leamy

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The Maryland nutrition program, under the direction of the Chief of the Bureau of Child Hygiene, was begun 3½ years ago and now employs the time of two nutritionists. The Bureau of Child Hygiene, one of the seven bureaus of the State Department of Health, carries on its activities in the 23 county health units in the State.[2]

Staff Conferences.

In planning and executing the nutrition program, the nutritionists have the advantage of a close relationship with the other members of the staff of the Bureau of Child Hygiene, namely the consultants in obstetrics and pediatrics, the nurse supervisors, and the consultant in maternity nursing. One of the important factors in this relationship is the weekly staff conference held by the bureau chief. At these conferences the activities of each staff member are reviewed, future plans are discussed, individual county activities that might affect staff activity are presented, and reports are given on related problems. These reports are particularly helpful because they enable the nutritionist to receive first-hand information of progress of activity which had been started in a county. For example, one of the nurse supervisors might have visited a school cafeteria with which the nutritionist had worked, or the consultant in obstetrics might have observed the activities of a volunteer worker.

Staff conferences not only give the nutritionist the benefit of the experience of others but assist in enabling her to enlist cooperation in handling special problems. Recently a large amount of reference material on nutrition was prepared for the nurses to include in their notebooks. It was felt that a discussion of the material was necessary for its intelligent use. Obviously, it was impossible for the nutritionists to visit each county in the near future, so the nurse instructors assumed the responsibility of distributing the material in many of the counties, thus making available information which it would otherwise have taken nearly 6 months to disseminate.

Staff conferences facilitate program planning and prevent two members of the State staff from attempting special work in the same county simultaneously, as well as making occasional planning of joint activity most helpful. For example, the consultant in obstetrics introduced the nutrition program to a previously uninterested county through his prenatal clinics, thus making possible continuous nutrition service.

Another most vital result of the weekly staff conference is the appreciation of the aims, problems, and results of the programs of coworkers.

[1] This paper is one of a series presented at the Conference of State Maternal and Child Health Directors with the Children's Bureau, Washington, March 24–26, 1941. A limited number of reprints of this paper and of the papers by Dr. Edwin R. Watson (The Basis of the Nutrition Program, in Georgia's Department of Public Health) and by Dr. A. F. Whitsitt (Nutrition Services in a County Public Health Program), which appeared in The Child, July 1941, will be available from the Children's Bureau on request.

[2] A brief account of activities developed in the early stages of the Maryland nutrition program was given by Miss Leamy in The Child, April 1939, p. 231.

Without these conferences the work of integrating coherently the nutrition program with the other activities of the Bureau of Child Hygiene would seem most difficult.

Advisory Committee.

Another tie between the nutrition program and the other activities of the Bureau of Child Hygiene is the fact that a representative of each field in which the nutrition program functions is a member of the nutrition advisory committee. The members include the Bureau Chief as chairman, the consultants in obstetrics and pediatrics, the nurse-supervisor, the editorial assistant, and representatives from the State Departments of Welfare and Education, the University of Maryland, Johns Hopkins University, the State Extension Service, and the Maryland Children's Aid Society. The committee meets semiannually to review the nutrition program, make suggestions regarding future plans presented for consideration, and review material made available for publication. Each member is at the disposal of the nutritionists, on request, for individual consultation.

Although the advisory committee has been most helpful as a group, its greatest value has been that of relating the State nutrition service to that of other agencies. Through the State department of education it has been possible to expand the school-lunch program, carry on a joint adult-education program, and participate in round-table discussions with home-economics teachers.

The contacts with the University of Maryland's medical and extension services and with Johns Hopkins University have been the means of obtaining students and volunteer workers to give instruction in prenatal clinics, while the county home-demonstration agents have not only given nutrition service at the prenatal clinics, but have also organized groups to train lay leaders for clinic service, participated in joint class instruction, and arranged for group meetings at which the nutritionist speaks.

Through the State Department of Welfare the nutritionists have arranged to hold staff conferences with county welfare workers and have obtained surplus commodities for use in instruction of food preparation at prenatal clinics, while the Maryland Children's Aid Society has arranged group meetings on nutrition.

Through its understanding of the aims of the nutrition program the advisory committee has been most active in stimulating the program throughout the State, a fact that has contributed much to its progress.

Relations With County Health Officers.

Although much planning is done before the nutrition service actually reaches a county, it is upon the county health officer that the actual execution of the program depends. Without his backing, little could be accomplished; without his advice, many pitfalls would be met. In Maryland each county is a separate entity—each has its individual problem. A State worker who starts on a State-wide program feels that the time will never come when these individual characteristics will be clearly defined in her mind, but it is early apparent that one plan will not fit 23 situations. For example, the activities which fit a county of 15,000 population scattered in an isolated, mountainous area with a few desperately poor mining communities, where there is a staff of 5 public-health nurses, few organized clinics, and no definite school-lunch program, will be vastly different from those of an adjoining county with a population of about 70,000 centered in a large industrial city—a county with a staff of 9 nurses, a supervisor, 2 physiotherapists, and an assistant county health officer, and with a highly organized clinic program in several health centers. The county health officer helps the nutritionist to interpret her program in such vastly differing situations, and often actually plans a detailed schedule of her activity which he sends to her a week before her anticipated visit. It is through the health officer that the nutritionist gains entree into various county organizations and activities. His backing is behind each new undertaking, and because of his backing and his presence at staff conferences many activities gain momentum and continue to be effective.

Program Adapted to Local Conditions.

Two counties may be mentioned to show how the nutrition program varies with the county situation. The program of a mountainous, rural county has been built around work with

other county agencies. Visits have been made to the one-room schools with the county supervisor of education to discuss with teachers ways of inaugurating a hot school lunch; two community groups were organized with the cooperation of the Work Projects Administration recreation leader, and with these groups a series of 12 classes were held in which the county home-demonstration agent taught nutrition, representatives of the county health department discussed health problems, and the recreation leader led games. Not only have staff conferences been held with the nurses, but many conferences have been held with the welfare workers. Family visits to demonstrate the teaching of nutrition have been made with both nurses and welfare workers.

In a second county with a larger staff and more extensive facilities, the nutrition program has been concentrated within the health-department group. Numerous staff conferences have been held; family visiting has been done on a demonstration basis with the nurses; nutrition service has been given both at well-child conferences and at prenatal clinics; and special meetings have been held with mothers whose children are under the care of physiotherapists.

In some counties the health officer feels that the school-lunch program is the first and best approach to meeting the nutrition needs of the county; in other counties the prenatal clinics seem the best medium through which to start nutrition work. In all counties the nurses are the most important channel through which nutrition information can be disseminated, and their interest and cooperation is most difficult to enlist unless the health officer appreciates the aims of the nutrition program and has a part in its planning and execution.

Certain Phases of the School-Lunch Program.

The school-lunch program has seemed of particular value as part of the State-wide nutrition program. In some counties, however, a problem has arisen in connection with cafeterias operating on a concession basis. It often happens not only that these cafeterias are managed by untrained persons but that they serve food which is undesirable though financially profitable. To overcome such situations, the health officers of the two counties most keenly affected suggested a survey of their entire school-lunch program. The result indicated that the conditions which so definitely influenced the nutrition of the school child were caused by lack of knowledge on the part of the managers.

Through the cooperation of the Department of Education, it was possible to have a week's institute for school-lunch managers which included classes in cooking, cost accounting, food selection, sanitation, counter arrangement, and food service. The results have been far more gratifying than was anticipated. Some of the managers have completely rearranged and redecorated their cafeterias to make them more attractive places in which to eat; all managers have emphasized the use of whole wheat and other dark breads, fruit, and simple desserts; some have reported a 33⅓-percent increase in their sales of milk, the discontinuance of the sale of soft drinks, and, most important of all, a new interest by the teachers in the cafeteria and its educational possibilities. This winter it was possible to have two follow-up meetings at which the managers reported their progress and the principals contributed to a round-table discussion.

A report of the school-lunch program would not be complete without mention of the important work the nurses have done in connection with it. They accompany the nutritionist on her annual visit, and then discuss with the manager and the school principal, the report of the visit. They constantly encourage the manager to follow the suggestions which are made and supplement the manager's work in interesting the teachers in the teaching of nutrition.

Because of the interest in nutrition teaching, and because of the fact that the teachers seem to have felt that it was difficult to obtain teaching material on nutrition, a teaching outline, "Nutrition in the School Lunch," was prepared for use in elementary schools. Two county supervisors of education volunteered to use the pamphlet on an experimental basis this year so that it could be revised and used on a State-wide basis next year. The results of the experiment have been excellent.

Another activity which is related to the school-lunch program, and which has been of

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value in arousing both school and community interest in nutrition, is the survey. In one county the nurses undertook to survey the food habits of nearly 1,200 white children, in an effort to start a school-lunch program. The health committee members interviewed all the children in the first 4 grades. In grades 5 to 7, the children recorded their own daily intake. The results revealed in startling fashion the need for improving the diets of many children. The county now has a school-lunch program.

The school-lunch program has also been a means of cooperative activity with the county sanitarians, as the nutritionist has had the opportunity of making food-service inspections with the county sanitarians, and, in turn, they have participated in the school-cafeteria institute by contributing material on food preservation and dishwashing.

Correlation With Other Services.

One medium of nutrition activity has been the oral-hygiene program. In a county where preschool dental service is being conducted on an experimental basis, nutrition service has also been included. The material obtained in this manner has been carefully analyzed and correlated with the dental findings. As yet, however, the results show little conclusive evidence relating nutrition habits to dental decay.

A survey has been made by the nutritionist in which the diets of prenatal patients have been carefully analyzed on the basis of their food intakes recorded at a clinic interview. The results, which indicated, for example, that nearly 40 percent of the group had an intake of less than 1,000 calories a day, and that but 4 percent had enough iron, have been used widely in staff education, and have done much to stimulate demands for nutrition service at prenatal clinics.

Use of Volunteer Workers.

Because of limited nutrition service and because of the demand for the teaching of nutrition at prenatal clinics, volunteer service has been of primary importance. The use of student dieticians has been mentioned; in some counties it has been possible to obtain graduate dieticians or home-economics teachers who offer their services in addition to the services of a home-demonstration agent. In still other counties, lay leaders assist in the program. In preparing the volunteers for their work, each worker is given a definite outline of the material to be presented at the clinics. Only people who have had training at food clinics are encouraged to conduct conferences with individual patients, and in all instances an effort is made to have the volunteer observe the nutritionist work in the clinic before the volunteer is started out on her own. In the county in which lay leaders are used, two all-day institutes have been held in which the nutritionist executes all the demonstrations which the lay leaders are to give.

Staff Education Through Clinic Interviews.

Although in many counties the clinic situations are not such that the nurse can spend 2 half days with a nutritionist, the clinic interview has proved a valuable method of staff education where it has been possible. The nurse spends the first half day observing while the nutritionist conducts the clinic conference. On the second half day the nurse conducts the conference and the nutritionist observes and gives suggestions. Such a procedure has proved far more valuable than a single staff conference.

Correlation With Adult Education Activities.

The adult-education classes conducted in cooperation with the Department of Education have also proved a valuable activity. The plan requires that the county health department organize the group and furnish both the equipment and the material, and that the Department of Education pay a teacher for 10 2-hour lessons. The communities in which this procedure has been particularly successful are those in which the population lives in a small area. The problems of transportation in an area where the population is scattered have yet to be solved to make the procedure equally successful in a rural district.

These are the most important phases of the Maryland nutrition program at its present stage of development. The program is being revised constantly to meet the individual needs of each of the State's 23 counties in the hope of eventually creating some permanent activity for each.

Some Parental Attitudes Toward Handicapped Children

By Ellen Whelan Coughlin

Social Worker, Detroit Orthopaedic Clinic, Detroit, Mich.

Much has been written about the attitudes of parents toward their children, and it is generally agreed that these attitudes are the most powerful single factor influencing the development of the children's own personalities and their social relationships. The specific application of this to the particular problems of the handicapped child is not so well known, however, and it is a matter of intense interest to those who are dealing with this group of children.

It is natural to suppose that, since the family constitutes the area of most intense feeling, the presence of a handicapped child in the family group must have some special effect. The fact that the handicapped child requires a larger share of the attention, concern, personal services, and financial resources of his parents makes it impossible to disregard the handicap as a determining factor in the social relationships of the whole family. Since the child's attitude toward his handicap will be based on the example of those he sees about him, the importance of knowing as much as possible about the feelings of the parents could not be overlooked. For all these reasons an inquiry into parental attitudes toward handicapped children was begun in the Detroit Orthopaedic Clinic.

This agency, devoted to the care of handicapped boys and girls up to 21 years of age, introduced a mental-hygiene program 5 years ago under which qualified medical-social workers with child-guidance experience work intensively with selected cases.

From this selected group 51 cases in which both parents of the child were living and in which the case worker knew the attitudes of the parents were chosen for study. No children with cerebral palsy were included.

The patients selected were 5 to 20 years of age. Two-thirds of them were in the adolescent period during which handicapped children, like normal ones, face an intensification of their problems. Slightly more than one-third were girls. Two were Negroes. All but three of the children came from homes in which there were other children. The parents were foreign-born, or the home was characterized by foreign cultural patterns, in more than three-fourths of the cases.

Financially the families were divided into three groups according to whether they relied on agency help entirely, partly and intermittently, or only as a result of the strain of serious illness. Because of the intake policy of the agency, even those whose resources came nearest to being adequate were in the marginal income group; nevertheless, about half of the families included might never have come to the attention of an agency had it not been for catastrophic illness.

All the children had serious orthopedic conditions. In 9 instances the handicap was present from birth; in 11, the illness occurred before the child was 2 years of age so that there would be no conscious memory of an earlier experience as a normal child; in 12 cases, onset of handicap occurred before 6 years; in 12 cases between the ages of 6 and 12; and in 7 cases between 13 and 15 years.

Only 3 of the 51 patients were totally handicapped, 28 were able to participate in some normal activities with special adjustment of environment, and 20 could fit into the life of physically normal people by making some modification of their activities and slight adaptations of environment.

Parental attitudes in the group studied were classified either as constructive or destructive. The attitude considered most constructive was that of the relatively small number of parents who had sufficient intellectual insight and were so well-adjusted personally that they were able, while fully realizing the implications of the orthopedic problem, to accept it and turn their

attention and energies toward finding means of compensating for it. A second group of parents had a sufficient intellectual grasp of the situation, and a wish that the child might have as many compensations as possible, but lost part of their effectiveness in finding compensations for the child because of their own emotional reactions to the problem. A third attitude, also classed as constructive, was that of the parents who accepted the child at his level of physical limitation, realizing his difference, securing treatment for him, and allowing the handicap to affect their relationship toward him, as a person, very little. More than half of the parents studied fell into one of these classifications.

On a still lower level but classified as constructive because of its effect on the child was the attitude of complete acceptance of a handicapped child on an emotional level with very little or no intellectual insight. This minimum awareness most often occurred among foreign-born parents, particularly those of dull mental ability. Some of the parents in this group ignored the need for treatment entirely because of failure to understand what could be accomplished, and others placed their problems in the hands of an agency with a childlike gesture of turning over responsibility and feeling no need to do anything further themselves. Often, however, this attitude of acceptance had no ill effect on the child because of his feeling of perfect security in the parent-child relationship.

Among parents whose attitudes were considered destructive the difficulties resulted more frequently from emotional reactions than from intellectual deficiencies. The two attitudes most frequently encountered were overanxiety and overprotectiveness. These elements were present in more than half of the cases, occasionally even when the general parental attitude was considered constructive.[1]

Overstimulation of the patient to accomplish more than he was capable of was also noted frequently; in many cases this pointed to a strong parental drive to see the patient compensate for his handicap, but it was unfortunate when parents chose sublimation on an intellectual level for children of dull or mediocre ability. In a few cases parents, disappointed in a handicapped child, turned for their own satisfaction to the physically normal siblings and discriminated against the afflicted one. Very rarely, a tendency to hide the handicapped child from outsiders was noted.

More was known about the attitudes of mothers than of fathers, and in this small series more constructive attitudes were noted among fathers than among mothers. Whether this difference is only apparent, because of the workers' more frequent contact with mothers and better knowledge of their feelings, or whether it is actual, is not clear. It is conceivable that since a handicapped child makes greater and more constant demands on the time and attention of the mother, her attitude could not be so detached as the father's.

Examination of the factors which entered into the building up of attitudes showed that those which produce constructive attitudes in parents of handicapped children are the same as those which make it possible for persons to meet crises of any sort, i. e., intellectual realization of the situation plus emotional acceptance and determination to take whatever steps are necessary or possible to alleviate it. As would be expected, these qualities are encountered most often in parents whose own emotional needs are satisfied and who have adequate emotional security. Because such parents often find excellent and ingenious ways of meeting the problems of a handicapped child with a minimum of outside assistance, it is to the less adequate group of parents that the attention and effort of medical-social workers is most frequently directed.

Ignorance of parents as to orthopedic conditions and the emotional needs of handicapped children appeared to be the most frequent cause of a destructive attitude. Parents seldom have first-hand experience with infantile paralysis or osteomyelitis until the catastrophe occurs in their own families. Some parents measure the experience of others by their own slight

[1] This apparent contradiction arose from the fact that it is impossible to determine accurately at what point anxiety is justified and where it becomes excessive. The social workers noted it wherever they felt the effect of the parental feeling was unfavorable for the child.

information and refuse to believe that anyone is able to help them. Others blindly rush from one charlatan to another, grasping at straws, and still others deposit the whole problem on the doorstep of an agency and proceed to wait for miracles.

Another frequent cause of destructive parental attitudes was immaturity or inadequacy of the parents. These parents would have difficulty assuming a true parental role under any circumstances, and they are much more unfit to grapple with the challenge that a handicapped child presents. Although emphatically not to be desired, this immaturity and dependency on the part of parents is not always without some good results for the child. If the parents turn to an agency where their own problems are understood and the workers are able and willing to assume parental roles with them, the real parents may be assisted to find courses of action which are beneficial for the child.

High on the list of causes of destructive attitudes was fear—fear of surgery, fear that the child might grow worse, fear that he could never be economically independent, fear of what others in the social group might think. This factor usually existed in conjunction with ignorance and sometimes yielded to the social worker's tools of explanation, reassurance, and interpretation. It was not surprising that cultural patterns played an important role in determining the attitudes of parents toward their handicapped children. In some cases the handicap was accepted stoically or philosophically as a divine visitation. These parents were often kind and indulgent toward the child, attempting to "make up" to him for his deprivations. Sometimes, however, the parents cheerfully overlooked the need of the handicapped child for special planning and expected him to fit himself into family life as well as he could, and find his own compensations or do without them.

Emotional instability was also important as a cause of destructive parental attitudes. This factor seldom was present alone, but existed most frequently with immaturity and inadequacy, and all three were seen more often in mothers than in fathers.

Economic considerations were found to be much less important than might be expected, perhaps because clinic service for accepted cases is not given or withheld on a financial basis. With care assured, apparently cost seldom entered into the actual parent-child relationship. Discouragement because of the length of the treatment program and former unpleasant medical or surgical experiences also played important roles in determining attitudes, especially attitudes toward treatment.

Undoubtedly there was a large element of guilt in many of the cases where overanxiety and overprotection were manifested. However, though the case workers frequently recognized some elements of guilt, they hesitated to analyze this feeling more fully without the assurance of psychiatric consultation. A few cases were carried under the supervision of a psychiatrist. There were many other cases in which the workers considered that this service would have been beneficial if it had been available in the community.

The series of cases was next examined to determine whether parental attitudes toward these handicapped childern were subject to change. In 11 of the 51 cases there was not any indication of need for change, and in each of 14 additional cases there was 1 parent whose attitude was considered constructive. Thus in half the cases studied the child had at least 1 parent as a source of understanding and security in the home. There remained, however, 66 parents in whom workers were attempting to effect changes of attitude. This was felt to be completely accomplished with only 3 parents. Partial modification was brought about in the attitudes of 38, leaving 25 parents with unchanged attitudes. In only 6 cases was there total refusal of both parents to alter destructive attitudes.

The attitude of the parent toward treatment, although not to be confused with the parental attitude toward the child, is closely allied to it. Sometimes, though not always, one is an indication of the other.

In 42 cases parents acted jointly in matters of treatment. In only 1 case was a single parent able to block a major portion of the treatment plan. This reinforces the conviction of experi-

enced case workers, that if one parent can be won over to a course of action, he can safely be trusted to know the best way of persuading the other parent.

A few case examples bring out contrasts in parental attitudes. There is the approach of intelligent, well-adjusted parents whose only child was left at the age of 8 years with severe residual paralysis from poliomyelitis. They immediately set about bending all their efforts to making new plans and finding substitute means through which she could develop to her full mental and social capacity. They initiated the inquiry about treatment and meticulously followed out all the suggestions made by the doctor; at great personal sacrifice they allowed their daughter to spend long periods at a convalescent home. They persuaded her to accept willingly a transfer to a special public school for crippled children, over her natural resistance to a plan which took her away from a familiar parochial school where she had enjoyed considerable prestige. In order to be certain that she would continue to be included in the neighborhood group the other children were encouraged to make her yard their gathering place. Activities were discreetly and unobtrusively supervised, and several times wise parental intervention averted catastrophes. On one such occasion when a "show" offered no part for a slow-moving child on two crutches, the child was given the very satisfying job of directing and prompting the other "actors" from the wings. After a careful build-up over a 4-year period the parents made a special effort to purchase a piano in order to substitute an extra cultural advantage for some others which would inevitably be denied their child.

Another set of parents, who were foreign-born, faced the problem of a crippled boy of 4 years with very little intellectual appreciation of the implications for him. They trusted the medical aspect of it to an agency and followed treatment instructions without question. In the home their attitude of complete acceptance of the patient was so constructive from an emotional angle that they, and he, allowed his crippled condition to make very little difference in their lives. He was allowed to participate in all the neighborhood activities that he was able to share in and seemed to exercise his own judgment about ways and means of making a place for himself in spite of his handicap.

In both these cases the parental attitudes were in sharp contrast to that of the mother whose 14-year-old boy lost both hands in an explosion. She was an emotional person, thwarted in her marriage and concerned over her husband's alcoholism. She determined that her son must compensate for his loss by a legal career and was completely blind to the fact that his mental ability did not fit him to complete academic high-school subjects. She sought attention for him, demanding that he "show off" in spite of his own reluctance, and goaded him to an accomplishment which was impossible, in order to satisfy her own need that he achieve recognition.

Very often the orthopedic problem may be only one of many—the ultimate calamity which forces families to seek help in situations where economic pressure, mental illness, marital strain have been present for years. In one instance a mother had been dissatisfied with her marriage for a long time and had been severely worried because of her husband's intermittent unemployment. When she learned that her 12-year-old daughter was developing a curvature of the spine she began to project a great deal of her anxiety about other things onto the child, weeping constantly and refusing to believe the doctor when he told her the condition could be treated so as to leave no permanent handicap. In this case it was possible to relieve enough of the other pressures, through the case-work process, to enable the mother to function fairly well as a constructive parent.

Occasionally there is an example of complete rejection of a handicapped child. In one case an immature father, who had been an athlete, turned against his only son who was so crippled as a result of infantile paralysis that he could never participate in any sport; he could never achieve recognition in the only field that his father considered important. The father lavished his affection on the younger daughter, who was a robust, active girl, and the patient withdrew more and more to the protection of his mother, indulging in crying spells, tantrums, and threats of suicide.

Rarely, a pathetic parent is encountered who attempts to shield a deformed child from all outside contacts. Even examination and treatment were denied to one 12-year-old girl who suffered from a severely progressive type of spinal curvature. It is difficult to be certain in some of these cases whether the parents' principal concern is for themselves or whether their behavior develops genuinely from excessive sensitiveness about the child's feeling in regard to his handicap.

Although individual cases vary too much to permit categorical classification of parental attitudes, all parent-child relationships may be considered from a twofold emotional and intellectual angle. If the attitudes of parents of the handicapped children chosen for this study were to be examined in this light, they might be grouped from top to bottom in four steps.

In the first group are those parents whose emotional acceptance of their handicapped child is complete, providing him always with a sense of security and preserving him from feelings of inferiority. The intellectual element is present to such a degree that both parents face the problem realistically, seek help, provide special

training, find recreational outlets, and wherever possible manipulate environment so that the effect of the handicap is counteracted.

Complete emotional acceptance of the child with his handicap is also seen in the second group of parents, but sometimes without their having full intellectual realization of the problems the child must face. Perhaps these parents seem unaffected by the handicap, and this philosophical point of view may often contribute something very desirable to the child's attitude toward his condition.

Among the third group of parents may be found adequate intellectual realization of the problem, but some unfavorable factor rising out of the emotional side of the picture is present. These parents may show an excess of anxiety, protectiveness, or ambition. There may be indifference or lack of real sympathy. It does not necessarily follow, however, that parents in this group neglect to seek medical care. Sometimes the most destructive attitudes drive them to the most meticulous observance of treatment suggestions.

The fourth group of parents is characterized principally by attitudes that are wholly destructive, such as extreme ignorance combined with stubborn unwillingness to be influenced, or rejection of a handicapped child who fails to live up to parental expectations. Fortunately, parents of these types were not often found.

A final glance at the results of this inquiry shows that the attitudes of parents of handicapped children are not different from the attitudes of parents of normal children, but that they are intensified.

The problems which a handicapped child presents bring to the surface many deep-seated feelings which might otherwise be suppressed, perhaps not even suspected. The physical handicap may precipitate expression of the parents' true feeling toward the child. For instance, parents may successfully cover up the fact that a child is unwanted until he becomes physically handicapped; then their feelings of guilt for not wanting him are stirred up to such an extent that they become oversolicitous or overprotective.

There is some inclination to accept the handicapped child on a level lower than his age. It is more common to restrict his horizons than to push him too hard. Physical handicaps seem to have less effect on parental attitudes in the lower social strata than in the more intelligent and privileged groups. In general, there were observed more destructive attitudes in mothers than in fathers. The attitudes of father and mother toward a child were different more often than they were identical, but parents were much more likely to share a constructive attitude than a destructive one.

Conclusions from a series of cases such as this provide some background against which case workers may compare their own experiences. It is hoped that they may be useful in bringing about a more understanding service to handicapped children.

BOOK NOTES

Public Health

Report on community health eduiation

Community Organization for Health Education is a report presented by the committee on community organization for health education of the American Public Health Association to the Public Health Education Section and the Health Officers Section (American Public Health Association, 1790 Broadway, New York, 1941. 120 pp. 9 cents).

In the introduction to the report Prof. C. E. Turner, chairman of the committee, says:

> For some years now health education has been making a continually larger place for itself among the tools for promoting the public health. Experienced and professionally trained workers have developed excellent programs in schools, in health departments, and in private agencies. But the community is a unit, and it is natural that public-health workers should consider the development of a unified health-education program for the community as a whole.

The report describes experiences and experiments in community-health education in various parts of the country. Mr. Riley studied the functions assumed by

health departments, schools, and private agencies in correlated health-education programs in 14 States.

The report should prove of interest to agencies contemplating the development of health-education activities on a community basis.

Children's camps in Massachusetts. Health and social aspects of children's summer camps, opportunities in nutrition for campers, camps for children with special problems, and the role of juvenile camps in national defense are covered in a camping number of *The Commonhealth*, quarterly bulletin of the Massachusetts Department of Public Health, Boston (Vol. 28, No. 1, Jan., Feb., Mar., 1941).

Standards for camp sanitation which are given in detail as prepared by the State Department of Public Health and adopted by 92 local boards of health apply to overnight camps and trailer camps as well as to recreational camps. Standards for health protection are outlined by Lendon Snedeker, M. D., chairman, Massachusetts Committee on Camps of the American Academy of Pediatrics.

The special camps described include: Tuberculosis camps, camps for diabetic children, camps for children with special problems, and the management of cardiac children at summer camps.

* * *

SCHOOL HEALTH SERVICES; A STUDY OF THE PROGRAM DEVELOPED BY THE HEALTH DEPARTMENT IN SIX TENNESSEE COUNTIES, by W. Frank Walker and Carolina R. Randolph. Commonwealth Fund, New York, 1941. 198 pp. $1.50.

Analysis of approximately 58,000 records was involved in this Tennessee study, which seeks to answer some questions that health workers in schools and administrators planning school-health programs have long been asking.

Among the conclusions reached are the following:

1. Repeated examinations did not appear to increase the rate of corrections except in the case of visual defects.
2. The presence of a parent at the examination proved to be a more important factor in securing correction of defects than a nursing visit to the home following the examination.
3. Only 33 percent of dental defects, about 4 percent of throat defects, and 12 to 13 percent of visual defects were corrected following any examination.
4. The correction of visual, dental, and tonsil defects was higher among young children if a parent was present at the examination.
5. There was a significant drop in the incidence of dental, throat, and nutrition defects among 6-year-old children entering school in 1936 as compared with 1930.
6. Systematic attention to infants and preschool children was seen to yield a return in terms of a lower incidence of dental and tonsil defects at the age of 6 years. No difference was noted with regard to visual defects nor, interestingly enough, with regard to nutrition defects.
7. There is evidence of improvement in the health status of 12-year-old children between the years 1930 and 1936.

The final chapter is entitled, "What should the school health program be?" The authors here give constructive suggestions based on the results of the study.

J. M. B.

Nutrition

Nutrition Conference viewed by Survey Graphic Under the general title, "Food for a Stronger America" the *Survey Graphic* for July 1941 (Vol. 30, No. 7) contains a special section on the National Nutrition Conference for Defense, held in Washington in May. The statements of the conference speakers, pointed up with photographs, form a composite picture of a nation "faced with a serious problem of nutrition," where a great many of the people are not receiving the food they need for strength of mind and body, but where the gravity of the situation is mitigated by "the hopeful and challenging fact that we now have the scientific knowledge, the means, and the national will to do something about it."

* * *

A TEXTBOOK OF DIETETICS, by L. S. P. Davidson and Ian A. Anderson. Paul B. Hoeber, New York, 1941. 324 pp. $4.25.

The two Scottish authors of this book, both physicians who, according to Sir John Boyd Orr's foreword, have done original research on nutrition in relation to health and disease, have produced an original text based on lectures given to medical students at the University of Aberdeen.

The book attempts to equip the general practitioner to give sound advice on the relation of diet to the maintenance of health and to undertake with confidence the dietetic treatment of disease. To that end the customary sections on diet in health and disease are preceded by a brief general survey of the Nation's diet and a concise "but for clinical purposes complete account of the physiology of nutrition." Economic considerations are never lost sight of; for each disease there are given two samples of daily diets, one of which is for the patient with a very limited income.

The sections on therapeutic diets carry out the authors' conviction that the scientific principles underlying all dietary recommendations must be stated since "no dietetic restrictions should be imposed that cannot be justified on biochemical, physiological, or clinical grounds." Moreover, the dietetic treatment of each disease is considered in relation to the associated therapy and hygiene so that dietetics appears in true perspective as a therapeutic measure.

To treat nutrition and dietetics so broadly in a book of modest size has necessitated careful selection of facts that are both well-established and of practical importance.

DETERMINATION OF NUTRITIONAL STATUS, by E. W. McHenry. *Canadian Public Health Journal*, Vol. 32, No. 5 (May 1941), pp. 231–235.

A DIETARY SURVEY IN HALIFAX, by E. Gordon Young. *Ibid.*, pp. 236–240.

ENQUÊTE SUR L'ALIMENTATION HABITUELLE DES FAMILLES DE PETITS-SALARIÉS DANS LA VILLE DE QUÉBEC, by J. Ernest Sylvestre and Honoré Nadeau. *Ibid.*, pp. 241–250.

A DIETARY INVESTIGATION IN TORONTO FAMILIES HAVING ANNUAL INCOMES BETWEEN $1,500 AND $2,400. *Ibid.*, pp. 251–258.

A DIETARY SURVEY IN EDMONTON, by George Hunter and L. Bradley Pett. *Ibid.*, pp. 259–265.

NUTRITION IN CANADA; AN EDITORIAL. *Ibid.*, pp. 268–269.

The Canadian Council of Nutrition, organized in 1938, has formulated dietary standards for the country, has compiled tables of composition of Canadian foods, and has carried out large-scale studies of food consumption of individual members of low-income families in each of four principal cities: Halifax, Quebec, Toronto, and Edmonton. The dietary standards are set forth and the findings of each of the dietary studies are reported in the May 1941 issue of the *Canadian Public Health Journal*, which is devoted almost entirely to nutrition.

The outstanding findings, as reviewed in an editorial, are that the food supplies of low-income families are not satisfactory and that mothers are the least well-fed members of family groups. There is a shortage of protective foods, resulting in deficiencies in intake of calcium particularly for children, of the B vitamins for all individuals, and of iron for women and children. Some families are not spending enough for food to purchase an adequate diet, but there are a sufficient number who could obtain enough of the right kinds of food for the money that they are now spending to point the urgent need for a comprehensive program of nutritional education.

THE INFLUENCE OF NUTRITIONAL EDUCATION IN FAMILIES OF THE MULBERRY AREA OF NEW YORK CITY, by Dorothy L. Bovee and Jean Downes. *Milbank Memorial Fund Quarterly*, Vol. 19, No. 2 (April 1941), pp. 121–146. 20 cents.

Between July 1937 and December 1939 the nurses and the nutritionist of the Mulberry Health Center carried out a special study to find out whether intensive instruction in nutrition in the home will bring about improvement in children's habits of eating and other practices related to nutrition. The food and health habits of the children in 135 families were rated at the beginning of the study and again after 9 months. In 90 families a special program in nutrition education was carried on; in half of these families the instruction was done by the public-health nurses with the advice of the nutritionist; in half, the nutritionist did the teaching herself. The remaining 45 families served as a control group.

In the families in which special educational work was done, there was a marked increase in the use of milk, eggs, fruits and tomatoes, and vegetables. There was relatively little change in the habits of the children of the control families. The children in the nutritionist's group showed greater improvement than did the children in the nurses' group of families. It should be pointed out, however, that the nutritionist was able to devote all her time in the homes to nutrition teaching, whereas the nurses included nutrition teaching in a program of general health supervision. In none of the groups was marked improvement noted in hours of sleep and bedtime-habits, which were determined to a considerable extent by the crowded conditions under which all the families lived.

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

Pending Bill for Federal Aid for Education

The current bill to provide Federal aid to education takes into consideration emergency needs growing out of the defense situation. Senator Thomas on April 7, 1941, introduced the present bill (S. 1313) known as the Educational Finance Act of 1941 "To strengthen the national defense and promote the general welfare through the appropriation of funds to assist the States and Territories in meeting financial emergencies in education and in reducing inequalities of educational opportunities." Hearings on the bill were held before a subcommittee of the Senate Committee on Education and Labor, April 28–30.

The bill would provide an appropriation of $300,000,000 of Federal funds each year to help the States provide additional school facilities for children of workers in centers of defense industry and to equalize educational opportunities within States and among the States, especially for children in rural areas, children living on Federal reservations, and children of migratory workers. The bill specifically provides for the continuance of State and local responsibility for the administration of the schools.

Incorporated in the bill is an interesting section on findings of fact, including (1) public elementary and secondary schools throughout the Nation for all children are essential to a national program of total defense; (2) State and local school jurisdictions in many cases are not able to provide adequate educational opportunities in areas adjacent to defense activities and industries; (3) millions of children, especially those in rural areas, those residing on Federal properties, and the children of migratory workers, are in school districts in which the school facilities are wholly inadequate; (4) the States are unable to reduce substantially the inequalities of educational opportunities, because of differences in tax-paying ability in relation to the number of children of school age.

BOOK NOTES

SUMMARY OF YOUTH EMPLOYMENT ENQUIRY, APRIL 1941. Canadian Welfare Council, Ottawa, Canada. 19 pp. Mimeographed.

This statement summarizes replies to inquiries sent to child-welfare agencies and to a few private individuals in Canada to find out whether employment under present conditions is attracting an increasing number of school children.

No heavy increase was reported from any area in the number of boys and girls of compulsory-school-attendance age who were dropping out of school. A fairly steady increase (about 10 percent) was found in the number of work permits issued to minors.

The comment is made that:

> Difficulties facing youth today have not reached a sharply acute form for the general community in relation to employment. But the shadow of the wastage of the last 10 years has not lifted. With that experience in mind, everything possible under present-day conditions should be done to safeguard youth against the heartbreaking experiences of the last decade, to assure them decent home standards, reasonable wage levels and working conditions, skilled vocational training, and the best in vocational guidance and placement facilities. It is reasonable to press for these things. They are sane, and their sanity will increase the effectiveness and resource of youth for the simple reason that they broaden the outlook of the individual personality.

Children's Bureau News

Several important changes in the staff of the United States Children's Bureau during recent months have been announced by its Chief, Katharine F. Lenroot.

Martha M. Eliot, M. D., Assistant Chief of the Bureau since 1934, became Associate Chief in May 1941. She continues to collaborate with the Chief in developing and carrying out policies governing the entire field of the Bureau's work and to have special responsibility for the health work of the Bureau.

Charles I. Schottland was appointed in May as Assistant to the Chief of the Bureau. Mr. Schottland is a graduate of the University of California at Los Angeles, has had postgraduate training in social work and law, and is a member of the bar of the State of California. In recent years he has served as State Relief Administrator, Deputy Director of the Department of Social Welfare, and Executive Director of the Federation of Jewish Welfare Organizations of Los Angeles. Mr. Schottland will assist the Chief and the Associate Chief in developing policies governing the administration of the Children's Bureau and will have special responsibility for the Bureau's activities in the general field of social service.

These administrative changes do not affect the Industrial Division, whose Director, Beatrice McConnell, continues to report to the Chief of the Bureau on all matters relating to child labor and the employment problems of youth.

The Maternal and Child Health Division and the Crippled Children's Division have been combined as the Division of Health Services, with Edwin F. Daily, M. D., formerly Director of the Maternal and Child Health Division, as Director of the new division. Hart E. Van Riper, M. D., formerly Assistant Director of the Maternal and Child Health Division, is Assistant Director for Maternal and Child Health; and A. L. Van Horn, M. D., formerly Assistant Director of the Crippled Children's Division, is Assistant Director for Crippled Children.

Dr. Robert C. Hood, formerly Director of the Crippled Children's Division, resigned from the Children's Bureau in June and is now Director of the Maternal and Child Health Division, Florida State Board of Health.

Jacob Yerushalmy, Ph. D., was appointed in January as Director of the Division of Statistical Research. He succeeded Robert J. Myers, Ph. D., who left the Bureau to become head of the Division of Wage and Hour Statistics of the Bureau of Labor Statistics. Dr. Yerushalmy received his doctor's degree at Johns Hopkins University in 1930. He has conducted research with the National Research Council at the University of Illinois and at Princeton University and has been instructor in mathematics at Johns Hopkins University, statistician in the New York State Department of Health, and statistician in the Division of Public Health Methods of the National Institute of Health, United States Public Health Service.

Katherine Bain, M. D., was appointed in September 1940 as Director of the Division of Research in Child Development. Dr. Bain has been instructor in clinical pediatrics at Washington University School of Medicine in St. Louis, Mo., and has done research work in the field of allergy, particularly in relation to infant feeding. Dr. Bain is in charge of health studies of the Bureau.

Ethel C. Dunham, M. D., formerly Director of the Division of Research in Child Development, continues to give consultation service on problems of premature and newborn infants and is devoting herself to special studies on the care of premature infants.

Administrative officials of the Children's Bureau include the following persons:

Chief.—
Katharine F. Lenroot.
Associate Chief.—
Martha M. Eliot.
Assistant to the Chief.—
Charles I. Schottland.
Industrial Division.—
Beatrice McConnell, Director.
Elizabeth S. Johnson, Assistant Director in Charge of Research.
Elizabeth B. Coleman, Assistant Director in Charge of Child Labor Administration.
Division of Health Services.—
Edwin F. Daily, Director.
Hart E. Van Riper, Assistant Director for Maternal and Child Health.
A. L. Van Horn, Assistant Director for Crippled Children.
Naomi Deutsch, Director of Public Health Nursing Unit.
Edith M. Baker, Director of Medical Social Work Unit.
Child Welfare Division.—
Mary Irene Atkinson, Director.
Child Guidance Division.—
Elsa Castendyck, Director.
Division of Research in Child Development.—
Katherine M. Bain, Director.
Social Service Division.—
Agnes K. Hanna, Director.
Division of Statistical Research.—
Jacob Yerushalmy, Director.
Editorial Division.—
Isabelle M. Hopkins, Director.
Administrative Section.—
Laura Elmore Warren, Administrative Assistant to the Chief.
State Audits Unit.—
William J. Maguire, Administrative Officer.
Merit System Unit.—
Ruth O. Blakeslee, Consultant in Maternal and Child Welfare Services.
Central Files Section.—
Ella O. Latham, Head.
Mail, Correspondence, and Stenographic Section.—
Anna T. McNulty, Head.

Defense Activities

The Chief of the Bureau was appointed in January 1941 as Child Welfare Consultant to the Coordinator of Health, Welfare, and Related Defense Activities, Paul V. McNutt.

The Bureau is represented on the interdepartmental council and on several of the committees that advise the Coordinator in the development of programs. Regional consultants of the Bureau serve similarly on regional advisory councils organized by the Coordinator's Office. Through its representation on the Advisory Committee on Nutrition the Children's Bureau participated actively in the organization and conduct of the National Nutrition Conference for Defense held in Washington May 26–28, 1941.

Mr. McNutt also requested the assignment of a staff member of the Children's Bureau to serve in the Coordinator's Office as liaison officer in matters relating to children. Charles I. Schottland, Assistant to the Chief, has been assigned to serve in this capacity.

At the request of F. H. LaGuardia, Director of Civilian Defense, the Associate Chief of the Children's Bureau was appointed in August 1941 as liaison officer from the Children's Bureau to assist his office in the development of a child-welfare program in connection with civilian defense.

The letters of the Coordinator of Health, Welfare, and Related Defense Activities and the Director of Civilian Defense to Miss Lenroot follow:

From the Coordinator of Health, Welfare, and Related Defense Activities:

I am writing to inquire whether you, as Child Welfare Consultant to the Coordinator of Health, Welfare, and Related Defense Activities, will be responsible through the Children's Bureau, for assisting me in formulating and executing plans, policies, and programs designed to assure the protection of children during the national-defense emergency. This work, of course, will be carried on in cooperation with the advisory committees functioning under the Program Planning Branch of this office, and with other agencies of the Federal Government and nongovernmental agencies concerned with the health and welfare of children.

Although the well-being of children is closely related to the health of the general population, the security of family life, and provision for nutrition, recreation and legal and social protection, children present special problems which must be considered in reference to all aspects of their welfare. Adequate consideration must be given to such subjects as the following: Provision for the infant and preschool child in families where the mother is employed in an occupation related to national defense; protection of the health and welfare of children in military or industrial defense communities; planning wholesome

recreation for children in such communities; maintaining and enforcing child-labor standards; preparing plans and material for training volunteers to serve in child-health and child-welfare agencies or in child-care centers; anticipating needs for additional trained personnel for child-health and child-welfare work.

These subjects need to be considered with reference to:

(*a*) Special needs of children in military and industrial defense areas;

(*b*) Advance planning for evacuation of children under conditions of grave emergency;

(*c*) Measures essential for safeguarding the health and well-being of children throughout the country.

The Children's Bureau being the agency in the Federal Government charged with special responsibility for child welfare, is the appropriate agency to develop for the Coordinator's Office comprehensive plans for assuring proper safeguards to children, whose health and well-being are of primary importance in the program of national defense. Many aspects of child welfare do not fall within the scope of any of the present advisory committees, and all phases of health and welfare under the defense program need to be reviewed to make sure that they are properly coordinated in relation to child welfare, and that adequate emphasis is given to the protection of children. When general policies and plans have been developed, they can be translated into action with the assistance of Regional Advisory Councils and cooperating State and local agencies.

In order that close cooperation with other services in the Office of the Coordinator may be maintained, I suggest that you assign a member of the staff of the Children's Bureau to serve in my office as liaison officer in matters relating to children.

From the Director of Civilian Defense:

In connection with the work now under way in the development of plans for evacuation, and its relation to children's welfare, I find that it will be most desirable to have a liaison officer from your Department to assist in this office in the preparation of a program as far as child welfare is concerned.

Owing to the broad background of Dr. Martha M. Eliot in this particular branch of the subject, I am requesting that she be appointed as the liaison officer from your Bureau to assist our office in this work.

Civilian Defense Program

The United States Office of Civilian Defense in Washington, D. C., has issued over the signature of F. H. LaGuardia, Director, a bulletin entitled Local Organization for Civilian Defense. This contains a suggested civil-defense ordinance and chart of organization made to fit the needs of the average city in the United States. This plan can be adapted to city, county, and other political subdivisions.

It is stated that other bulletins will be issued at intervals and that the Regional Offices of Civilian Defense will furnish advice and assistance in solving local problems.

National Citizens Committee Appoints Director

The appointment of Mrs. Betty Eckhardt May as Director of the National Citizens Committee of the White House Conference on Children in a Democracy was announced as of August 16. Mrs. May has had extensive field experience in community organization, youth leadership, and adult education. She takes the place of H. Ida Curry, who had retired from active service with the New York State Charities Aid Association in 1938 but consented to assist the National Citizens Committee to organize its work last year.

The office of the committee will be at 122 East Twenty-second Street, New York.

Institute on World Organization

An institute organized by a small committee as the first step toward establishing a permanent center for the study and dissemination of the principles and method of world organization will be held in Washington, D. C., September 2–13. The American University has offered the facilities of its campus for the use of the institute.

A study will be made of the first comprehensive experiments in world government—the League of Nations, the International Labor Organization, and the Permanent Court of International Justice. The subjects discussed will include the work of the so-called technical organizations, such as economics and finance, communications and transit, health, social questions, intellectual cooperation, nutrition, and narcotics control. Lecturers are, for the most part, experts who have been closely associated for years with the work of the League. Ten nationalities will be represented. Arrangements have been made for publication of the lectures.

Application for membership in the institute should be made to the Committee Headquarters, 1907 F Street NW., Washington, D. C. The registration fee is $5.

Symposia at University of Chicago

A 5-day series of symposia will be held at the University of Chicago beginning September 22 in connection with the celebration of the University's fiftieth anniversary. The symposia will deal with the newest fundamental advances in the biological, physical, and social sciences, the humanities, law, business, religion, and social service, in keeping with the theme of the university's celebration—New Frontiers in Education and Research.

Thirty-nine universities, including 6 in foreign nations, and 15 museums, research organizations, and Government agencies will be represented in the symposia.

Second American Congress on Obstetrics and Gynecology

The Second American Congress on Obstetrics and Gnyecology will be held in St. Louis, Mo., April 6–10, 1942.

The general plan for the program will be much the same as that of the first Congress, which was held in Cleveland in September 1939. There will be sectional meetings for the various groups—physicians, nurses, public-health workers, administrators, and educators—and general sessions for all members. Some of the evening sessions will be open to the public. Various committees have already been set up.

Dr. Fred L. Adair, chairman of the American Committee on Maternal Welfare, Chicago, is the chairman of the executive committee of the Congress.

The program committee, with Dr. E. D. Plass as chairman and Dr. William F. Mengert as secretary, is working with the following subcommittee chairmen: Dr. Ralph A. Reis, for the Medical Section; Georgia Hukill, for the Nursing Section; Dr. R. C. Buerki, for the Hospital Section; Dr. Edwin F. Daily, for the Public-Health Section; and Dr. Clair Folsome, for the Educators Section.

Dr. Robert L. DeNormandie is chairman of the committee on public meetings.

The committee on scientific and educational exhibits is headed by Dr. H. C. Heseltine, with Dr. Charles Galloway as secretary.

Dr. Buford Hamilton, chairman of the membership committee, has organized a central committee representing each of the five groups interested in the Congress. State membership committees are being formed in all the States. There are also committees for special organizations.

Dr. Joseph A. Baer is serving as chairman of the committee on lay publicity.

Dr. George W. Kosmak heads the committee in charge of professional publicity for the various sections.

Dr. William C. Danforth is chairman of the budget and finance committee and Dr. Goodrich C. Schauffler, of the publication committee.

Oct. 27–Nov.— International Labor Conference, New York.
General sessions open to the public.

CONFERENCE CALENDAR

Sept. 29–Oct. 3 National Recreation Association. Twenty-sixth National Recreation Congress, Baltimore, Md. Information: National Recreation Association, 315 Fourth Avenue, New York.

Oct. 4–8 National Society for Crippled Children of the United States of America. Twentieth annual convention, Louisville, Ky. Permanent headquarters: Elyria, Ohio.

Oct. 6–10 National Safety Council. Thirtieth National Safety Congress and Exposition, Chicago, Ill.

Oct. 9–11 American Academy of Pediatrics, Boston, Mass. In charge of arrangements: Dr. Clifford Grulee, 636 Church Street, Evanston, Ill.

Oct. 14–17 American Public Health Association. Seventieth annual meeting, Atlantic City, N. J. Permanent headquarters: 1790 Broadway, New York.

Oct. 20–24 American Dietetic Association. Twenty-fourth annual meeting, St. Louis, Mo. Information: American Dietetic Association, 185 North Wabash Avenue, Chicago, Ill.

Oct. 27–31 American Dental Association. Eighty-third meeting, Houston, Tex. Permanent headquarters: Chicago, Ill.

Nov. 11–14 Southern Medical Association. Thirty-fifth annual meeting, St. Louis, Mo. Permanent headquarters: Birmingham, Ala.

Nov. 14–15 Child Study Association of America. Two-day institute on Family Morale in a World at War, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York.

Dec. 4–6 National Society for Prevention of Blindness. Annual meeting, New York. Permanent headquarters: 1790 Broadway, New York.

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